Table 1 *Average change of variables between month 0 and month 8*

Variable	*d*	*SD*	*t Value*
Isotope activity index of eight PIP* joints	− 0·61	0·90	−4·07
Tender and swollen PIP joints (No)	− 1·83	3·06	−3·53
Grip strength (right + left hand) (mmHg)	−10·0	30·2	−1·98
Swollen joints of the body (No)	− 4·98	4·98	−5·95
Pain (visual analogue scale)	− 2·61	3·18	−4·92
ESR* (mm/h)	−21·8	28·1	−4·66

*PIP=proximal interphalangeal; ESR=erythrocyte sedimentation rate.

swollen joints of the body. A combination of these last three variables may give a still higher t value, but then the correlation between the variables should also be taken into account. Such a procedure would also rest heavily on the assumption of normal distribution, an assumption we have avoided by using non-parametric methods. The present results of the total patient group confirm our previous conclusions[1] that our scintimetric method, when applied to proximal interphalangeal joints, is very sensitive in reflecting changes in local synovitis activity but is not a representative measure of the overall changes in activity of the disease.

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Reference

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Injections and physiotherapy for the painful stiff shoulder

SIR, Dacre *et al* are to be congratulated on their paper. They have confirmed that neither injections nor physiotherapy have any effect on the natural history of the painful stiff shoulder, but that injections are a great deal cheaper. I suspect that if medical audit were to be applied to many of the other conditions commonly treated by rheumatologists or physiotherapists it would produce similar findings. But why, when 'treatment' has clearly been shown to have no effect, continue to use it? I have found that most patients with adhesive capsulitis are content to await spontaneous improvement once it is explained to them that they have a benign self limiting condition from which they will eventually make a good recovery, even if this may take up to 18 months. I do, of course, inject patients with acute subacromial bursitis due to a ruptured calcific deposit, in which the results can be quite dramatic. I also use injections, but with less conviction, for the various localised lesions such as bicipital tendinitis, which were excluded from the study.

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